Healthy Louisiana Case Management
Transition of Care Plan

Date:	Anticipated Discharge Date:
Offender Name: DOC#: Medicaid ID #: DOB:	
MCO: MCO Case Manager: MCO Case Manager Contact Info: Phone: Email:	Probation & Parole Officer and Contact Info: Name: Office address: Phone: Email:

MENTAL HEALTH/SUBSTANCE USE

Severe Mental Illness: ☐ Yes ☐No If yes, diagnosis: Date of last DOC evaluation:	Mental Health Level of Care:
Co-occurring Substance Use Disorder (SUD): ☐ Yes ☐ No If yes, SUD diagnosis:	Substance Use Treatment Level of Care:
History of Suicide Watch within last 6 months: ☐ Yes ☐ No	
History of withdrawal or detox: ☐ Yes ☐ No	
Psychotropic medications dispensed at discharge with corresponding 30 day written prescription? ☐ Yes ☐ No	
If Yes, list below or attach medication information: Drug Name: Dosage: Duration: # of Pills Given: Drug Name: Dosage: Duration: # of Pills Given: Drug Name: Dosage: Duration: # of Pills Given: Drug Name: Dosage: Duration: # of Pills Given: Drug Name: Dosage: Duration: # of Pills Given:	
Compliant with medications? ☐ Yes ☐ No	

Pending Mental Health Clinic Appointments:

Date:	Time:	Location:
Date:	Time:	Location:
Date:	Time:	Location:

Support Program Applied for (i.e., housing, employment, transportation, other):

Pending Support Program Appointments:

Date:	Time:	Location:
Date:	Time:	Location:
Date:	Time:	Location:
Date:	Time:	Location:

MEDICAL

Medical Condition: ☐ Yes ☐ No

If yes, Medical Diagnosis:

Chronic Illness medications dispensed at discharge with corresponding 30 day written prescription?

☐ Yes ☐ No

If Yes, list below or attach medication information:

Drug Name:	Dosage:
Duration:	# of Pills Given:
Drug Name:	Dosage:
Duration:	# of Pills Given:
Drug Name:	Dosage:
Duration:	# of Pills Given:
Drug Name:	Dosage:
Duration:	# of Pills Given:
Drug Name:	Dosage:
Duration:	# of Pills Given:

Infectious Disease Medications Given at Discharge: ☐ Yes ☐ No

Prescription Written for Infectious Disease Medication and Given at Discharge: ☐ Yes ☐ No

Compliant with medications? ☐ Yes ☐ No

Relevant laboratory values:

Pending Medical Clinic Appointments:

Date:	Time:	Location:
Date:	Time:	Location:
Date:	Time:	Location:
Date:	Time:	Location:
Date:	Time:	Location:
Date:	Time:	Location:

RESIDENCE PLAN

Name of Person/Facility Residing:
Address:
Phone Number:
Additional Contact Info:

MISCELLANEOUS

Is the member a veteran? ☐ Yes ☐ No Is the member pregnant? ☐ Yes ☐ No
Entitlement Program Enrollment: VA: ☐ SSI: ☐ Medicare: ☐ Other:
If Not Currently Enrolled, Entitlement Program Applied for: VA: ☐ SSI: ☐ Medicare: ☐
Other: Date Entitlement Programs applied for:

Released from:
Printout of Current Medications Given to Offender: ☐ Yes ☐ No
List Individualized or Non-Individualized Devices/Aids Required Upon Release, if any:

If other:

Any Additional Information for Probation and Parole Staff: